



## Behavioral Health Provider Claims Inquiry Form

CaSonya Thomas, MPA, CHC  
Director

PROVIDER INFORMATION	
Name	
Address	
Phone	Fax

CLIENT INFORMATION
Date Submitted:
Client Name:
Client Medi-Cal #:
Date of Services:
Reason for inquire:

Requested by (please print)\_\_\_\_\_

Signature\_\_\_\_\_

Date \_\_\_\_\_

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